CLINICAL RISK ANTICOAGULANT EVALUATION

Anticoagulant Considerations	**Resident Initials**	**Resident Initials**	**Resident Initials**	**Resident Initials**	**Resident Initials**	**Resident Initials**
Anticoagulant order with dosage & diagnosis (write out order with diagnosis)						
Laboratory orders are present and correct (as indicated)						
Medication written correctly on MAR with laboratory results documented below administration time (as indicated)						
Laboratory values are present in chart under the appropriate tab (as indicated)						
Medication is administered and documented on MAR						
Physician notified of any side effects or laboratory abnormal values (as indicated)						
Dietician aware of the anticoagulant (SNF)						
Nurses have documented any s/s of bleeding bruising, etc. or lack thereof						
Care plan is present and correct (for SNF)						

Quality Assurance Performance Improvement Risk Management Tool Date: _____ Unit: _____

CLINICAL RISK DIABETIC EVALUATION

Diabetic Considerations	Resident Initials	Resident Initials	Resident Initials	Resident Initials	Resident Initials	Resident Initials
Insulin orders with current dosage & diagnosis (Write out order with diagnosis)						
Oral agent orders with current dosage & diagnosis (Write out order with diagnosis)						
Are there orders for Fasting Blood Sugars (FBS)?						
Are there Sliding Scale orders with high/low parameters to notify the Physician?						
Were there noted times where the FBS was either below or above the parameters and was the Physician notified?						
Is there a Hypoglycemic Protocol in place?						
Are there lab orders for HgA1C? (If indicated)						
Nurses documenting any signs & symptoms of hyper/hypo-glycaemia?						
Care Plan is present and appropriate?						

Quality Assurance Performance Improvement Risk Management Tool Date: _____ Unit: _____

Dialysis Communication Report – Dialysis Center Staff

Resident: _____ Facility: _____ Room #: _____ Date: _____

This Page is to be completed by the Dialysis Center staff and returned to the Facility with the Resident

Time resident received: _____ Time resident released: _____

Temperature: _____ Respirations: _____ Pulse: _____ B/P: _____

Weight before dialysis: _____ Weight after dialysis: _____ Intradialytic Weight: _____

Labs performed: _____

Access site dressing change (check one) ☐ Yes ☐ No

Lung assessment: _____

Any c/o Pain or Hurting in Anyway: ☐ Yes ☐ No Prior to Transport to RD Center? ☐ Yes ☐ No

If yes, list treatment: _____

List medications, dosage, frequency given prior to RD Treatment the day of or ☐ check here indicating MAR attached.

Medication	Dosage	Frequency

Dialysis completed (check one) ☐ Yes ☐ No

Problems/Concerns: _____

Signature: _____ Date: _____

Dialysis Communication Report – Facility Staff

Resident: _____ Facility: _____ Room #: _____ Date: _____

This Page is to be completed by the Nursing staff upon residents return to the facility

Temperature: _____ Respirations: _____ Pulse: _____ B/P: _____

Location of dialysis access site: _____ Type: _____

Lung assessment: _____

Edema: ☐ Yes ☐ No If Yes, Location(s)/Amount: _____

Thrill present (check one) ☐ Yes ☐ No ☐ N/A

Bruit present (check one) ☐ Yes ☐ No ☐ N/A

Has the residents temperature been elevated in the last 24 hours (check one) ☐ Yes ☐ No

If Yes, list highest temperature, treatment & response _____

Any c/o Pain or Hurting in Anyway ☐ Yes ☐ No If Yes, Time: _____

If yes, list treatment: _____

List medications, dosage, frequency given prior to RD Treatment the day of or ☐ check here indicating MAR attached.

Medication	Dosage	Frequency

Problems/Concerns: _____

Nurses Signature: _____ Date: _____

PAIN EVALUATION RECORD

Faculty:	Residents Name:	Nursing Station:

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Are you having pain now? Yes or No *Note response **If yes**, ask the resident: "Please rate your pain, with zero being no pain and ten being the worst pain you can imagine." **If No,** Score is 0. Note response 0 – 10	11-7																															
	Y/N																															
	Score																															
↓ ↓		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	7-3																															
	Y/N																															
	Score																															
↓ ↓		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	3-11																															
	Y/N																															
	Score																															
How often are you having pain? 1. Almost Constantly 2. Frequently 3. Occasionally 4. Rarely *Note response 1 – 4		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	11-7																															
	7-3																															
	3-11																															
Have you limited your day to day activities because of pain? Yes or No *Note Response		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	7-3																															
	3-11																															
Has pain made it hard for you to sleep at night? Yes or No *Note Response		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	11-7																															
For residents who are unable to answer: Do they have signs and symptoms of pain such as Non-verbal sounds, Vocal complaints of pain, Facial expressions, or Protective body movements or postures?		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	11-7																															
	7-3																															
	3-11																															
	If yes, please document accordingly.																															

Period:	Patient Name:	Room/Bed:	Page: